

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>	1. TRANSMITTAL NUMBER: 04-04	2. STATE Nevada
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION	4. PROPOSED EFFECTIVE DATE 1/1/04	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN                      ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN                      ☒ AMENDMENT

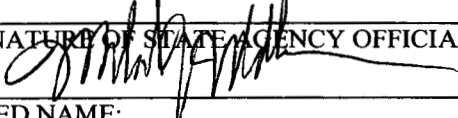
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: 42CFR 432.725, 435.733, 435.832 and Section 1616, 1924, of the Social Security Act	7. FEDERAL BUDGET IMPACT: a. FFY 2004                      \$ None b. FFY 2005                      \$ None
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attachment 2.6.A, Page 5 & 4a <del>Supplement 6 to Attachment 2.6.A (2 pages)</del> <i>PJD</i> Supplement 12 to Attachment 2.6-A Page 1 <i>PJD</i>	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 2.6.A, page 5 Supplement 6 to Attachment 2.6.A (2 pages)


10. SUBJECT OF AMENDMENT:  
Federal Cost of Living Adjustments for Social Security reflected in adjustments to Standards for Optional State Supplementary Payments

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT                      ☒ OTHER, AS SPECIFIED:  
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED                      The Governor's Office does not  
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL                      wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: John A. Liveratti, Chief DHCFP/Medicaid 1100 East William Street, Suite 102 Carson City, Nevada 89701
13. TYPED NAME: Michael J. Willden	
14. TITLE: Director, DHR	
15. DATE SUBMITTED: MAR 0 4 2004	

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED: March 4, 2004	18. DATE APPROVED: 5/11/04

PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2004	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Linda Minamoto	22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health

23. REMARKS:  
Block 8: Pen & ink change made to reflect material submitted by the State on April 29, 2004.

State: NEVADA

Citation	Condition or Requirement
435.725 435.733 435.832	<p>4. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple:</p> <p>a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no company spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the:</p> <ul style="list-style-type: none"><li>° AFDC level, or</li><li>° Medically needy level:</li></ul> <p>(Check one)</p> <p><input checked="" type="checkbox"/> AFDC levels in Supplement 1 to Attachment 2.6.A page 1</p> <p><input type="checkbox"/> Medically needy level in Supplement 1</p> <p>b. Amounts for health care expenses described below that have not been deducted under 3.c. above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple, and are not subject to the payment by a third party.</p> <p>(I) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.</p> <p>(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amount are described in Supplement 3 to <u>ATTACHMENT 2.6-A</u>)</p>
435.725 435.733 435.832	<p>5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an institutionalized couple:</p> <p>A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period:</p> <p><input checked="" type="checkbox"/> No.</p> <p><input type="checkbox"/> Yes (the applicable amount is shown on page 5a.)</p>

State:

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Citation

Condition or Requirement

1924 of the Act  
435.725  
435.733  
435.832

2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care:

Personal Needs Allowance (PNA) of not less than \$30 For Individuals and \$60 For Couples For All Institutionalized Persons.

- a. Aged, blind, disabled:  
Individuals \$ 35  
Couples \$ N/A

For the following persons with greater need:

Institutionalized individuals with no community spouse living in the home but with other dependant family members in the home as described in Attachment 2.6.A page 5.

Supplement 12 to Attachment 2.6-A page 1 describes the Greater need, describes the basis or formula for determining the deductible amount when a specific amount is not listed above; and lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

- b. AFDC related:  
Children \$ 35  
Adults \$ 35

For the following persons with greater need:

Supplement 12 to Attachment 2.6-A describes the greater need describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

- c. Individual under age 21 covered in the plan as specified in Item B. 7. of Attachment 2.2 -A.  
\$ 35.

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TN No. 04-04  
Supersedes  
TN No. 00-09

Approval Date MAY 11 2004

Effective Date 01-01-04

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

In addition to the \$35.00 PNA allowed in Attachment 2.6.A Page 4a, persons with greater need identified in Attachment 2.6.A Page 4a, Institutionalized individuals with no Community Spouse at home, as described in Attachment 2.6.A Page 5 #4.a, for Post Eligibility Determinations are allowed an additional Personal Needs Allowance based on household size.

HOUSEHOLD SIZE	Additional PNA Allowed
1 family member	\$139.00
2 family members	\$173.00
3	\$207.00
4	\$241.00
5	\$275.00
6	\$309.00

For households greater than 5 add \$34.00 for each additional person.

The greater PNA deduction is to allow the difference between the 1996 AFDC Need Standard Amount used in the Maintenance Needs Allowance, which is frozen at the 1996 rate, and the current TANF Need Standard Amount.

The AFDC amount used in the Maintenance Need Standard is stated in Supplement 1 to Attachment 2.6.A Page 1.

Disclosure Statement for Post-Eligibility Preprint

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is #0938-0673. The time required to complete this information collection is estimated at 3 hours per response, including the time to review instructions, searching existing data resources, gathering the data needed and completing and reviewing the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland, 21244-1850 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C., 20503.